hearing speech & Deaf center of greater cincinnati

PATIENT INFORMATION

DATE _____

Patient's Name | Date of Birth | Age

Street Address | City | State | Zip

Home Phone # ( ) | Work # ( ) | Cell # ( )

Social Security # | *Circle Sex M F* | Marital Status | Race

Patient's Employer | Occupation | Email

Emergency Contact | Emergency Contact Phone #

Family/Referring Doctor

INSURANCE INFORMATION (PLEASE GIVE CARD TO RECEPTIONIST)

Primary Insurance | Phone #

Insured Name | Relationship to Patient

Insured Policy ID # | Group #

Insured Date of Birth | Insured Employer | Insured Social Security #

Insurance Coverage through (circle one) Employer Individual Policy Workers Comp Auto Accident Policy

Secondary Insurance | Phone #

Insured Name | Relationship to Patient

Insured Policy ID # | Group #

Insured Date of Birth | Insured Employer | Insured Social Security #

Insurance Coverage through (circle one) Employer Individual Policy Workers Comp Auto Accident Policy

If Medicare is secondary
(circle reason) Employer Spouse has insurance Veteran Disabled Other

If Patient is a Minor

Mother's Name | Date of Birth | Home Phone #

Mother's Employer | Work # | Social Security #

Father's Name | Date of Birth | Home Phone #

Father's Employer | Work # | Social Security #

Please Read and Sign below

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to my physician on claims for which they have accepted assignment, and I authorize the physician to submit a claim to Medicare for payment on my behalf. I request that payment under the medical insurance program be made to my physician on any bills for services furnished to me by my physician for which they have accepted assignment. I further release my physician to release medical information concerning my treatment to Blue Shield or other insurance carriers and I authorize payment of medical benefits from those carriers to be made directly to my physician on claims for which they have accepted the assignment. I also understand that I am responsible for payment for services not covered by the Medicare program.

I authorize my physician's office to provide my medical information or other organizations or entities for the determination and payment of benefits. I authorize my physician's office to permit my insurance companies or third party payors to review/audit my medial chart if they so request. I assign benefits otherwise payable to me to my physician. I understand that I am financially responsible for the charges for any services rendered to me by my physician(s).

I have reviewed the practice's **PRIVACY POLICY** _____ (initial here).

I have reviewed the **OFFICE FINANCIAL POLICY**_____(initial here).

I have reviewed the **CONSENT for TREATMENT**_____(initial here).

Signature

PATIENT DEMOGRAPHICS

Patient Name: Full Address:	Date of Birth: Age:	Gender: M ☐ F ☐

HOUSEHOLD INCOME	
$0 to $9,999	☐
$10,000 to $14,999	☐
$15,000 to $19,999	☐
$20,000 to $29,999	☐
$30,000 to $39,999	☐
$40,000 to $49,999	☐
Other Amount	☐
# of People in Household	

RACE	
White/Caucasian	☐
Black/African American	☐
Asian	☐
American Indian or Alaskan Native	☐
Pacific Islander or Native Hawaiian	☐
Multi-Racial	☐
ETHNICITY	
Hispanic	☐
Non- Hispanic	☐

REFERRAL TYPES/CATEGORIES			
Agency	☐	Professional	☐
BSVI/BVR	☐	School	☐
Client	☐	Staff/Board Member	☐
Employer	☐	Yellow Pages	☐
Friend/Relative	☐	Print/TV/Radio Media	☐
Friend/Relative	☐	HSDC Mailer	☐
Hospital/Physician/ Medical Practice	☐	HSDC Special Event	☐
Job & Family Services	☐	Web-Site	☐
KBDD	☐	OBDD	☐
Nursing Home	☐	Other	☐

COUNTY OF RESIDENCE

Butler	☐	Warren	☐
Clermont	☐	Kenton	☐
Dearborn	☐	Highland	☐
Adams	☐	Campbell	☐
Hamilton	☐	Ohio	☐
Boone	☐	Brown	☐
Other:			

REFERRAL SOURCE SPECIFIC

Name:	
Address:	
Do you live in the city of Cincinnati? **yes** **no**	Do you live in the city of Middletown? **yes** **no**

As a United Way agency, we are required to collect this information. This information is being collected for census reporting only. Your answers will be kept confidential and no identifying information will be shared. No information will be used to determine eligibility for our services.

hearing speech & Deaf center of greater cincinnati

Agreement to Pay

Dear Patient:

Thank you for choosing the Hearing Speech & Deaf Center. The Center is a non-profit agency that has been serving the communication needs of the community since 1925. Please review the following policies regarding the payment of fees.

Fees are charged for the professional services rendered to the patient. The patient/family accepts complete responsibilities for payment. All patients are responsible for notifying the Center immediately of any changes in their insurance policy and for obtaining insurance related referrals and/or authorizations.

If the services rendered are covered by Medicare, Medicaid, private insurance companies, or third party agencies, the Hearing Speech & Deaf Center will verify coverage and will assist the patient/family by completing the necessary forms. If payment is not received from a private insurance company within 90 days from the date of submission, the patient will be responsible for payment of the balance in full. The patient will be responsible for any additional expense incurred in the collection of their balance. These fees may include attorney and, or collection agency fees as well as court filling fees in the event that legal action is taken.

The Hearing Speech & Deaf Center does not deny services to any patient because of documented inability to pay the full cost of services. **Persons wishing to apply for a reduced fee should complete the charitable service program application for approval prior to first appointment. Please see office manager, audiologist or speech pathologist for more information.**

MEDICARE/PRIVATE INSURERS:
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Where Medicare or private insurers do not fully cover services, the patient/family is responsible for the balance. We accept cash, check, MasterCard and Visa.

MEDICAID:
Medicaid recipients are required to bring their Medicaid card to each appointment.
Medicaid pays for services that it determines to be reasonable and medically necessary.

The Hearing Speech & Deaf Center reserves the right to discontinue services for non-payment of fees.

I have read the above statement and understand the Hearing Speech & Deaf Center's policies regarding the payment of fees.

_____ _____

Patient/ Guarantor/POA Signature Date

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INSURANCE RELEASE

Patient Name: _____ Birthdate: _____

I certify that the information given by me in applying for payment under Medicare (Title WVIII of the Social Security Act) and/or other Medical Insurance is correct.

I hereby authorize the release of any medical information necessary to process any claims submitted on my behalf of the Hearing Speech & Deaf Center.

I request that payment under Medicare and/or any other Medical Insurance be made directly to the Hearing Speech & Deaf Center and authorize them to submit a claim to Medicare and or any other medical insurance carrier on my behalf.

_____ _____

Authorized Signature/Relationship Date

MEDICARE POLICY ON HEARING TESTING

Medicare will only pay for services that it determines to be reasonable and necessary under section 1962(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would be otherwise covered, is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for the services. Medicare will deny payment for your hearing evaluation for the following reasons:

1. Not referred by a referring or attending physician

Or

2. Medicare has already paid for a hearing evaluation

Beneficiary Agreement:

I have read the above statement and understand that the Hearing Speech & Deaf Center cannot guarantee payment from Medicare on any hearing test. Therefore, if Medicare denies payment I agree to be fully responsible for payment.

_____ _____

Beneficiary/POA Signature Date

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Adult Hearing History Form

Name: _____ Date of birth: _____________

Occupation: _____ Place of employment: _____

Referred by: _____

Do you have a hearing problem? _____ If so, when was your hearing problem first noticed?

_____

Describe your hearing problem _____

Describe history of ear problems _____

_____

Describe any medical treatments you have received for your hearing problem _____

_____

_____

Family members with history of hearing loss _____

_____

Related complaints: (check appropriate items)

☐ head noises ☐ ear noises ☐ noise exposure ☐ vomiting

☐ ear pain ☐ ear fullness ☐ nausea ☐ dizziness

Hearing aid use: (check appropriate items)

☐ no experience ☐ wearing aid now ☐ aid satisfactory ☐ aid not quite adequate

Communication problems: (check items or situations where you have difficulty hearing)

☐ face-to-face ☐ in groups ☐ on telephone ☐ when telephone rings

☐ while watching tv ☐ hearing fire alarm

Describe any additional health problems _____

_____

List medication currently taking _____

_____

Other comments _____

_____

For office use only: Speech referral ☐ *yes* ☐ *no*

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Self-Assessment of Communication

(Adapted from Schow & Nerbonne, 1982)

*Please choose the best answer that best describes your situation:

1) Do you experience communication difficulties in situations when speaking with one other person? (for example, at home, at work, in a social situation, with a waitress, a store clerk, with a spouse, boss, etc.)

□ Almost Never
□ Occasionally (about ¼ of the time)
□ About half of the time
□ Frequently (about ¾ of the time)
□ Practically always

2) Do you experience communication difficulties in situations when conversing with a small group of several persons? (for example, with friends or families, co-workers, in meetings or casual conversations, over dinner or while playing cards, etc.)

□ Almost Never
□ Occasionally (about ¼ of the time)
□ About half of the time
□ Frequently (about ¾ of the time)
□ Practically always

3) Do you experience communication difficulties while listening to someone speak to a large group? (for example, at a church or civic meeting, in a fraternal or women's club, at an educational lecture, etc.)

□ Almost Never
□ Occasionally (about ¼ of the time)
□ About half of the time
□ Frequently (about ¾ of the time)
□ Practically always

4) Do you experience communication difficulties while participating in various types of entertainment? (for example, movies, TV, radio, plays, night clubs, musical entertainment, etc.)

□ Almost Never
□ Occasionally (about ¼ of the time)
□ About half of the time
□ Frequently (about ¾ of the time)
□ Practically always

5) Do you experience communication difficulties when you are in unfavorable listening environments? (for example, at a noisy party, where there is background music, when riding in an auto bus, when someone whispers or talks from across the room, etc.)

□ Almost Never
□ Occasionally (about ¼ of the time)
□ About half of the time
□ Frequently (about ¾ of the time)
□ Practically always

6) Do you experience communication difficulties when using or listening to various communication devices? (for example, telephone ring, doorbell, public address system, warning signals, alarms, etc.)

□ Almost Never
□ Occasionally (about ¼ of the time)
□ About half of the time
□ Frequently (about ¾ of the time)
□ Practically always

7) Do you feel that any difficulty with your hearing limits or hampers your personal or social life?

□ Almost Never
□ Occasionally (about ¼ of the time)
□ About half of the time
□ Frequently (about ¾ of the time)
□ Practically always

8) Does any problem or difficulty with your hearing upset you?

□ Almost Never
□ Occasionally (about ¼ of the time)
□ About half of the time
□ Frequently (about ¾ of the time)
□ Practically always

9) Do others suggest that you have a hearing problem?

□ Almost Never
□ Occasionally (about ¼ of the time)
□ About half of the time
□ Frequently (about ¾ of the time)
□ Practically always

10) Do others leave you out of conversations, or become annoyed because of your hearing?

□ Almost Never
□ Occasionally (about ¼ of the time)
□ About half of the time
□ Frequently (about ¾ of the time)
□ Practically always